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Issue Date: 19 August 2004

In The Matter of

Case No.: 2004 BLA 05285

Gloria Jean Whitt
Claimant

v.

Consolidation Coal Company
Employer

and

Consol Energy, Inc.
Carrier

and

Director Office of Workers' Compensation Programs
Party-In-Interest

DECISION AND ORDER
DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. Section 901 et seq. (the Act). In accordance with the Act and the regulations issued thereunder, the case was referred by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awardable to miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of miners who were totally disabled at the time of their deaths (for claims filed prior to January 1, 1982), or to the survivors of miners whose deaths were caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as "black lung."

A formal hearing was held before the undersigned on April 14, 2004, in Princeton, West Virginia, at which all parties were afforded full opportunity in accordance with the Rules of Practice and Procedure (29 C.F.R. Part 18) to present evidence and argument as provided in the Act and the regulations issued thereunder, set forth in Title 20, Code of Federal Regulations,

Parts 410, 718, 725, and 727.1 At the hearing, I admitted Director's Exhibits 1 through 77, Administrative Law Judge Exhibits 1 and 2, Claimant's Exhibits A through F, and Employer's Exhibits 1 through 8.2 The Claimant submitted her posthearing brief on June 15, 2004; the Employer submitted its posthearing brief on July 2, 2004; the Director did not submit a posthearing brief.

I have based my analysis on the entire record, including the exhibits and representations of the parties, and given consideration to the applicable statutory provisions, regulations, and case law, and made the following findings of fact and conclusions of law.3

JURISDICTION AND PROCEDURAL HISTORY

This case encompasses two separate claims. Mr. William D. Whitt filed a claim for black lung benefits on August 21, 2001, which was denied by the District Director on December 14, 2001, on grounds of abandonment (DX 1, 17). This denial was rescinded, apparently when it was discovered that there had been a mix-up in testing dates scheduled for the Claimant (DX 19). On August 13, 2003, the Director issued a Proposed Decision and Order granting benefits (DX 29). By letter dated August 20, 2003, the Employer disagreed with these findings and requested a formal hearing (DX 31).

Mr. Whitt died on February 6, 2002, and his widow, Gloria Jean Whitt, filed a claim for survivor's benefits on July 11, 2002 (DX 36). On August 29, 2003, the Director issued a Proposed Decision and Order denying benefits (DX 68); on September 24, 2003, the Claimant appealed this determination (DX 71).

Both claims were referred to the Office of Administrative Law Judges, and a hearing was held on April 14, 2004.

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1 The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001. Since the current claims were filed on August 26, 2001 and July 11, 2002, the new regulations are applicable.

2 The eight exhibits submitted by the Employer include exhibits that exceed the evidentiary limitations under the new regulations. The Employer offered the additional exhibits under the "good cause" exception, which I found did not apply (Tr. 15). I admitted all eight exhibits into the record for appeal purposes, but advised the parties that I would not consider them in making my determination. I note that in response to a similar challenge, the D.C. Circuit Court of Appeals recently upheld the validity of the new regulations. *National Mining Ass'n v. Dep't of Labor*, 292 F.3d 849 (D.C. Cir. 2002). In particular, the D.C. Circuit explicitly upheld §725.414, which limits the amount of evidence admissible in claims proceedings. *Id.* at 873-4. The court explained that the new evidentiary limits are not at all artificial, and "will enable ALJs to focus their attention on the quality of the medical evidence in the record before them." *Id.* at 874 (quoting 64 FR 54994 (Oct. 8, 1999)) (internal quotes omitted). Since the Fourth Circuit has not explicitly ruled on this issue, the validity of the amended regulations stands in this jurisdiction. Thus, in making my determination in this matter, and under strict adherence to the new regulations, I relied only upon those exhibits designated by the parties.

3 Citations to the record of this proceeding will be abbreviated as follows: "Tr." refers to the Hearing Transcript of the October 22, 2003 hearing; "ALJX" refers to the Administrative Law Judge's Exhibits; "DX" refers to the Director's Exhibits; "CX" refers to Claimant's Exhibit; and "EX" refers to Employer's Exhibit.

ISSUES PRESENTED

The issues contested by the Employer and the Director are:

1. Whether Mr. Whitt had pneumoconiosis.
2. If so, whether Mr. Whitt's pneumoconiosis arose out of his coal mine employment.
3. Whether Mr. Whitt was totally disabled.If so, whether Mr. Whitt's total disability was due to pneumoconiosis.
4. Whether Mr. Whitt's death was due to pneumoconiosis.

In addition, the Employer contests the length of Mr. Whitt's coal mine employment, its status as responsible operator, and whether the Claimant is eligible as Mr. Whitt's survivor (DX 74, 75; Tr. 17-17).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted and arguments made.

Background

The miner, William D. Whitt, was born on January 18, 1944, and died on February 6, 2002. He married his wife, Gloria Jean Whitt, on September 25, 1970 (DX 1, 43). At the time of his death, the miner was married and living with his wife, who has not remarried since the miner's death. Mr. and Mrs. Whitt do not have any children who are under the age of 18, or otherwise dependent (DX 1, 36). I find that Mrs. Whitt is the eligible survivor of the deceased miner, and that she has no dependents for purposes of augmentation of benefits.

Length of Coal Mine Employment

On his application for benefits, Mr. Whitt indicated that he worked as a coal miner for 32 years, and retired in January 2001 (DX 2). Mr. Whitt's Social Security Earnings record reflects that he last worked as a coal miner in 1999, for Island Creek Coal Co. (Consolidation Coal Co.) (DX 7). The Employer agrees that Mr. Whitt had 29 years of coal mine employment (Tr. 17). As this is consistent with the evidence of record, I find that Mr. Whitt had at least 29 years of coal mine employment, and that the Employer is properly named as the responsible operator.

Mrs. Whitt's Survivor's Claim

Applicable Standard

The Regulations at 20 C.F.R. § 718 apply to survivors' claims which are filed on or after April 1, 1980. 20 C.F.R. § 718.1. Because Mrs. Whitt filed her survivor's claim after January 1, 1982, 20 C.F.R. § 718.205(c) applies to this claim.

The regulations provide that a survivor is entitled to benefits only where the miner died due to pneumoconiosis. 20 C.F.R. § 718.205(a). The Claimant must establish that: (1) the decedent was a coal miner; (2) the decedent suffered from pneumoconiosis at the time of his death; (3) the decedent's pneumoconiosis arose out of his coal mine employment; and (4) the decedent's death was caused by pneumoconiosis or pneumoconiosis was a substantially contributing cause or factor leading to his death. All elements of entitlement must be established by a preponderance of the evidence. *Strike v. Director, OWCP,* 817 F.2d 395, 399 (7th Cir. 1987). The survivor of a miner who was totally disabled due to pneumoconiosis at the time of death, but died due to an unrelated cause, is not entitled to benefits. 20 C.F.R. § 718.205(c). If the principal cause of death is a medical condition unrelated to pneumoconiosis, the survivor is not entitled to benefits unless the evidence establishes that pneumoconiosis was a substantially contributing cause of the death. 20 C.F.R. § 718.205(c)(4).

The Board has held that death will be considered to be due to pneumoconiosis where the cause of death is significantly related to or significantly aggravated by pneumoconiosis. *Foreman v. Peabody Coal Co.,*8 B.L.R. 1-371 (1985). The United States Court of Appeals for the Fourth Circuit, in which the instant case arises, has held that pneumoconiosis is a substantially contributing cause of death if it hastens, even briefly, the miner's death. *See, Shuff v. Cedar Coal Co.,* 967 F.2d 977 (4th Cir. 1992), *cert. denied,* 113 S.Ct. 969 (1993). *See also, Brown v. Rock Creek Mining Corp.,* 996 F.2d 812 (6th Cir. 1993)(J. Batchelder dissenting); *Peabody Coal Co. v. Director, OWCP,* 972 F.2d 178 (7th Cir. 1992); *Lukosevicz v. Director, OWCP,* 888 F.2d 1001 (3rd. Cir. 1989).

The Board has held that in a Part 718 survivor's claim, the Judge must make a threshold determination as to the existence of pneumoconiosis under 20 C.F.R. § 718.202(a) prior to considering whether the miner's death was due to the disease under § 718.205. *Trumbo v. Reading Anthracite Co.,* 17 B.L.R. 1-85 (1993).

Existence of Pneumoconiosis

Pneumoconiosis is defined, by regulation, as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. § 718.201. The regulations at 20 C.F.R. § 718.203(b) provide that, if it is determined that the miner suffered from pneumoconiosis and engaged in coal mine employment for ten years or more, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. If, however, it is established that the miner suffered from pneumoconiosis but worked less than ten years in the coal mines, then the claimant must establish causation by competent evidence. *Stark v. Director, OWCP,*9 B.L.R. 1-36 (1986); *Hucker v. Consolidation Coal Co.,*9 B.L.R. 1-137 (1986). The Board has held that the burden of proof is met under § 718.203(c) where "competent evidence establish(es) that his pneumoconiosis is significantly related to or substantially aggravated by the dust exposure of his coal mine employment." *Shoup v. Director, OWCP,* 11 B.L.R. 1-1101-112 (1987). Specifically,

the record must contain *medical* evidence to demonstrate causation. *Baumgartner v. Director, OWCP,* 9 B.L.R. 1-65, 1-66 (1986)(administrative law judge cannot infer causation based solely upon claimant's employment history); *Tucker v. Director, OWCP,* 10 B.L.R. 1-35, 1-39 (1987)(it was error for the administrative law judge to rely solely upon lay testimony to find causation established).

The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. § 718.202(a).[4]

X-ray Evidence5

Exhibit No.	***Date of X-Ray***	***Date of Reading***	***Physician/ Qualifications6***	***Interpretation***
DX 52	11-11-93	11-11-93	Shahan	Lungs are clear
DX 52	2-11-00	2-11-00	Nicholas	Increased size and density of right hilum
DX 51	5-26-00	5-26-00	A. Ahmed	Right perihilar pneumonic infiltrate; underlying mild COPD
DX 50	6-8-00	6-8-00	Penuel	Nonsegmental pneumonitis compatible with radiation changes
DX 51	8-25-00	8-25-00	A. Ahmed	Opacity in right perihilar region could be postradiation pneumonitis/collapse of lung
DX 51	11-18-00	11-18-00	Olson	Right perihilar mass and relative decrease in right lung volume
DX 51	2-7-01	2-7-01	Shahan	Post radiotherapy change in right chest
DX 51	6-2-01	6-2-01	Rao	Stable postradiation change in

[4] The presumptions contained at §§718.304 - 718.306 are inapplicable, and these methods of demonstrating pneumoconiosis will not be further discussed.

5 The narrative x-ray interpretations are contained in Mr. Whitt's hospitalization and treatment records, and thus are not subject to the evidentiary limitations.

6 A "B-reader" is a physician, but not necessarily a radiologist, who has successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). A designation of "BCR" means that the physician is "certified" in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association.

				right perihilar region
DX 51	7-30-01	7-30-01	Rahman	Moderate right perihilar mass consistent with known malignancy
DX 49	11-8-01	8-24-02	Meyer/B, BCR	Negative for pneumoconiosis
DX 12	11-8-01	1-18-02	Navani/B, BCR	Read for quality only
DX 12	11-8-01	11-12-01	M. Patel/B, BCR	1/0, s, s
DX 53	11-8-01	5-31-02	Spitz/B, BCR	Negative
EX 1	11-8-01	5-24-02	Wiot/B, BCR	Negative
DX 54	2-5-02	2-5-02	D. Patel	Large lobulated and infiltrating mass right hemithorax

Numerous guidelines exist for evaluating x-ray interpretations. First, the actual number of interpretations favorable and unfavorable may be a factor. *Wilt v. Wolverine Mining Company*, 14 B.L.R. 1-70 (1990). At the same time, mechanical reliance on numerical superiority is not appropriate. *Akins v. Director, OWCP,* 958 F.2d 49 (4th Circuit 1992). Second, consideration may be given to the evaluating physicians' qualifications and training. *Dixon v. North Camp Coal*, 8 B.L.R. 1-344 (1985) and *Melink v. Consolidation Coal Company,* 16 B.L.R. 1-31 (1991). The interpretations from the doctors with the greater expertise may be accorded more evidentiary weight. *Taylor v. Director, OWCP*, 10 BRBS 449, BRB No. 77-610 BLA (1979). The qualifications of the doctor who provided the most recent evaluation may also bear on the evidentiary weight of the study. *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988). Finally, when faced with multiple interpretations of numerous x-rays, an administrative law judge should first evaluate the conflicting interpretations of one x-ray to determine whether that particular x-ray is negative or positive. Then, the administrative law judge resolves the conflict between the x-rays in context to determine whether pneumoconiosis is present. *Copley v. Arch of West Virginia, Inc.,* Case No. 93-1940 (4th Circuit June 21, 1994)(unpublished).

In this case, there are fourteen readings of eleven x-rays, almost all of which were taken while Mr. Whitt was hospitalized in connection with the side effects of his lung cancer treatment. Only one of these x-rays, performed on November 8, 2001, was interpreted as positive for pneumoconiosis, by Dr. Patel, who is dually qualified. However, Dr. Spitz and Dr. Meyer, who are also dually qualified, interpreted this x-ray as showing no evidence of pneumoconiosis. Given the preponderance of negative readings by the most highly qualified physicians, I find that this x-ray is not positive for pneumoconiosis.

There are no other positive x-ray readings in the record, or even any narrative reports that contain findings consistent with pneumoconiosis. Thus, I find that the Claimant has not established that Mr. Whitt had pneumoconiosis by a preponderance of the x-ray evidence.

Autopsy/Biopsy Evidence

Another method of establishing pneumoconiosis is with autopsy or biopsy evidence, pursuant to Section 718.202(a)(2). The record includes numerous biopsy reports, as well as several evaluations of the results of Mr. Whitt's autopsy.

a. *Dr. Larry Joyce*

Dr. Joyce performed an autopsy of Mr. Whitt's lungs on February 6, 2002, at the Claimant's request (DX 47). On his examination of Mr. Whitt's lungs, he found an invasive, poorly differentiated squamous cell carcinoma in the right lung, admixed with fibrous tissue, with a metastatic focus of tumor at the base of the left lower lobe. There was also extensive extension of tumor into the paratracheal and surrounding soft tissue, with intermixed fibrosis, and focal adhesion of the right upper lobe to the posterior thoracic wall, with intermixed squamous cell carcinoma. He identified acute bronchopneumonia in the right upper lobe, and some atelectasis, as well as pulmonary edema and emphysematous change in the lower lobes, and a mild degree of coal workers' pneumoconiosis, coal macules.

Dr. Joyce's final diagnosis was poorly differentiated squamous cell carcinoma; mild coal workers' pneumoconiosis, coal macules; vascular congestion and dilatation, some pulmonary edema, and areas of atelectasis; areas of interstitial fibrosis, particularly in the right upper lobe; pulmonary emphysema; and acute bronchopneumonia in the right upper lobe.

b. *Dr. Stephen T. Bush*

Dr. Bush reviewed medical records and slides at the request of the Employer, and prepared a report dated January 6, 2003 (EX 2). After examination of these records, as well as one slide of bronchial biopsy tissue obtained on October 13, 2000, and 25 autopsy slides, Dr. Bush concluded that Mr. Whitt's lungs showed no evidence of coal workers' pneumoconiosis.7 He noted that twelve of the autopsy slides contained significant lung parenchyma that was not affected by carcinoma or dense fibrosis from the treatment for carcinoma, and thus were suitable for evaluation for lesions of coal workers' pneumoconiosis. According to Dr. Bush, these slides contained no macules, micronodules, or macronodules of coal workers' pneumoconiosis. He stated that the earliest lesion of coal worker's disease is the macule, consisting of black dust pigment free in the tissue and in macrophages, associated with a reticulin or fibrous reaction, and also surrounded by focal dust emphysema. No such lesion was present in Mr. Whitt's lung tissue. He found only a rare small amount of dust pigment in the normal tissue of the lungs, without a fibrous reaction.

According to Dr. Bush, most of the lung slides showed distended air spaces, consistent with centrilobular emphysema typical of that seen with cigarette smoking. There were localized areas of acute bronchopneumonia, and several slides showed thrombi in vessels of varying size. The most prominently abnormal finding in the lung slides was poorly differentiated carcinoma,

7 Both Dr. Bush and Dr. Naeye examined a slide from Mr. Whitt's October 13, 2000 biopsy. However, the Employer did not designate any biopsy evidence on its evidence summary form. The regulations allow a party to submit no more than one report of each biopsy. I have no basis on which to choose one report over the other, and so I will not consider the discussion of the biopsy slide by either Dr. Bush or Dr. Naeye.

present as masses with areas of tissue necrosis, smaller nodules with tissue invasion, and invasion of blood vessels and lymphatics.

In Dr. Bush's opinion, coal workers' pneumoconiosis did not contribute to Mr. Whitt's death. Rather, his death was the result of carcinoma of the lung, with metastasis to the brain and adrenal glands. Apart from the carcinoma and the effects of treatment, Mr. Whitt did not suffer from a respiratory impairment before his death. Dr. Bush felt that the obstructive impairment observed by Dr. Mullins and Dr. Patel was due to centrilobular emphysema attributable to Mr. Whitt's significant smoking history. According to Dr. Bush, Mr. Whitt was totally disabled before his death due to his carcinoma and its metastasis, particularly to his brain. But coal workers' pneumoconiosis, or occupational exposure to coal dust, did not contribute in any way to a respiratory impairment or disability. Dr. Bush stated that coal mine dust exposure does not increase the risk of developing lung cancer, but cigarette smoking does.

Dr. Bush concluded that neither coal workers' pneumoconiosis nor coal dust exposure played any role in, or hastened Mr. Whitt's death. He stated that coal workers' pneumoconiosis was not present, and Mr. Whitt's exposure to coal mine dust did not contribute to the events leading to his death from metastatic cancer.

Dr. Bush noted that Dr. Joyce, the autopsy pathologist, had described the gross appearance of the lungs as having a few black streaks or foci of black pigment. According to Dr. Bush, if these black foci were microscopically diagnosable as coal workers' pneumoconiosis, the degree and extent would be minimal. He also noted that the autopsy prosector diagnosed "coal worker" macules, an assessment that he did not agree with. He stated that his evaluation of the histologic slides was more consistent with Dr. Caffrey's findings,8 that the changes were not those of coal workers' pneumoconiosis.

Dr. Bush stated that the fibrotic areas in the lymph nodes were not a basis for a diagnosis of pneumoconiosis, but represented a reaction to inhaled particles of mineral dusts. He indicated that, since these fibrotic areas were not in the lung parenchyma, they have no effect on pulmonary function. Dr. Bush concluded that the x-rays, CT scans, pulmonary function studies, and the clinical course of the malignancy leading to death were most consistent with gross and microscopic autopsy findings of no significant occupational lung disease.

c. *Dr. Richard L. Naeye*

Dr. Naeye reviewed medical records at the request of the Employer, and prepared a report dated November 10, 2002 (EX 3). Dr. Naeye also examined the biopsy tissue slide from October 13, 2000, as well as the 25 autopsy slides. He noted that most of the autopsy slides contained tissue from areas that received heavy radiation therapy and thus had large areas of fibrosis; many of them also had varying sized areas where normal lung tissue was largely replaced by poorly differentiated carcinoma. According to Dr. Naeye, in at least half of the pieces of tissue, airways and sometimes adjacent tissue were filled with acute inflammatory cells, evidence of the acute

8 Dr. Caffrey's report appears at DX 55. As neither the Claimant nor the Employer designated it among their exhibits submitted under the evidentiary limitations of the new regulations, I have not considered it in making my determination.

lobular pneumonia that was the terminal event leading to death. In the few pieces of tissue that were not irradiated, the centrilobular emphysema varied from mild to severe. There was also histologic evidence of mild to moderately severe chronic bronchitis.

Dr. Naeye stated that it was not easy to determine if there was any evidence of coal workers' pneumoconiosis, because the majority of tissue available for review was heavily damaged by the cancer and its therapy. There was a small amount of black pigment in the tissues in the undamaged areas, no more than is present in some persons who never worked in the coal mines. This pigment was present in tiny deposits, without accompanying very tiny birefringent crystals, toxic silica, or fibrosis. There were also larger birefringent crystals of non-toxic silicates, with no diagnostic value. Dr. Naeye noted that old, hyalinized collagen was associated with the black pigment only in two lymph nodes. As this was not present in lung tissue, it had no diagnostic value for coal workers' pneumoconiosis.

Dr. Naeye concluded that there were no lung tissue, x-ray, pulmonary function or arterial blood gas findings of coal workers' pneumoconiosis. He acknowledged the presence of very small amounts of black pigment in the subpleural areas and adjacent to small pulmonary arteries and airways, without accompanying fibrosis or focal emphysema. According to Dr. Naeye, the presence of such fibrosis and focal emphysema are the minimum evidence of tissue damage required to make a diagnosis of simple coal workers' pneumoconiosis. He acknowledged that there were some minimum findings possibly related to occupational exposure to coal mine dust present in one or two lymph nodes, but that they would not affect lung function.

Citing to studies, Dr. Naeye stated that there is not an increased frequency of lung cancer among coal miners, when cigarette smoking is taken into consideration.

Dr. Naeye noted that the findings of chronic bronchitis and centrilobular emphysema are very frequent consequences of cigarette smoking, which is several times more likely to cause such effects than occupational exposure to coal mine dust. According to Dr. Naeye, there was no good evidence that Mr. Whitt was disabled by bronchitis and emphysema, so the relative roles of cigarette smoke and coal mine dust were moot. He felt that any impairment in lung function and resulting disability were not the consequence of coal workers' pneumoconiosis, because the minimum findings required to make such a diagnosis were not present in his lungs. For that same reason, he felt that coal workers' pneumoconiosis neither hastened nor played any role in Mr. Whitt's death.

Dr. Naeye testified by deposition on April 2, 2004 (EX 8). Dr. Naeye indicated that he was a member of the committee that published its findings on coal workers' pneumoconiosis in 1979 in the *Archives of Pathology and Laboratory Medicine*. In discussing Dr. Joyce's gross findings on autopsy, Dr. Naeye noted that he described the lungs as pinkish tan to purple with only a few scattered black streaks on the surfaces, which according to Dr. Naeye was a "giveaway" that there was very little in the way of black pigment in the lungs or coal workers' pneumoconiosis. Dr. Naeye stated that there is usually more evidence of coal workers' pneumoconiosis on the outside of the lungs; with just a few scattered blackish streaks on the external part of the lung, one would know that coal workers' pneumoconiosis would not be very severe, because the findings inside the lung would be less.

According to Dr. Naeye, coal macules are the very tiniest lesions, as described by Dr. Joyce. He stated that there were very small amounts of pigment in the subpleural areas and adjacent to small airways and arteries, but there was no accompanying fibrosis. Without fibrosis, he could not make a diagnosis because fibrosis is the result of tissue damage, and the black pigment itself is carbon in an amorphous form, which is not toxic. In other words, the presence of black pigment itself is insufficient to diagnose a coal mine dust induced disease. Nor does the black pigment affect the functional capacity of the lung tissue. According to Dr. Naeye, there is a lot of black pigmentation in everybody's lungs, particularly in people in urban areas with a lot of air pollution.

Aside from the areas of the lung where there was cancer and radiation, and thus fibrosis, there were no other areas with fibrous tissue, rims of emphysema, or focal emphysema around black deposits.

Dr. Naeye also noted mild bronchitis, as reflected by the ratio of mucous to serous glands in the walls of the bronchi. He felt that Mr. Whitt's bronchitis was mild in comparison to coal miners who have also smoked. He found no reason to believe that Mr. Whitt's coal mine dust exposure had any role in his mild disability, or in his death.

Dr. Naeye described a coal macule as a very tiny black deposit found in the subpleural region of the lung, or adjacent to small arteries or an airway. In themselves, macules have no significance. If there is no toxic material in the mine dust, namely silica, the pigment itself is innocuous, and does not cause any abnormalities or predispose to any other disease. But even if Mr. Whitt were found to have mild pneumoconiosis consistent with the coal macules as Dr. Joyce described, they were far to mild individually and too few in number to have had any measurable effect on his lung function.

Biopsy Evidence[9]

Mr. Whitt underwent a biopsy on February 22, 2000, at Dr. Iosif's request (DX 50, 54). Dr. Joyce examined the slide, and found high grade dysplasia (carcinoma in situ), arising in the metaplastic bronchial surface epithelium; no evidence of invasive carcinoma; and moderate chronic inflammation. Dr. Joyce also reviewed the two right upper lobe biopsy slides obtained on February 28, 2000.[10] On the first slide, he identified bronchial mucosa showing squamous metaplasia; moderate to marked subepithelial chronic inflammation, and no invasive carcinoma. On the second slide, Dr. Joyce noted bronchial mucosa showing high grade squamous dysplasia arising in the metaplastic squamous epithelium; moderate to marked subepithelial chronic inflammation; and no invasive carcinoma.

9 All of the biopsy reports are part of Mr. Whitt's hospitalization and treatment records, and thus I have considered them in making my determination.

10 On February 28, 2000, Dr. Iosif performed a flexible fiberoptic bronchoscopy, which showed an invading bronchogenic carcinoma in the right hilum (DX 50).

Mr. Whitt underwent a bronchoscopy on March 7, 2000 (DX 54). Dr. Stavros Garantziotis noted the presence of a mass in the right upper lobe, and took a needle biopsy for evaluation. His impression was a neoplasm in the bronchus intermedius.

On October 13, 2000, Dr. V. Patel performed a bronchoscopy and needle aspiration (DX 51). He noted unhealthy appearing mucosa causing a partial block of the right upper lobe. His diagnosis was right upper lobe atelectasis and right perihilar mass, rule out recurrence of the carcinoma of the lung. The pathology report showed no evidence of malignancy.

Discussion

None of the various biopsies obtained from Mr. Whitt's lung produced any findings that are even suggestive of the presence of coal workers' pneumoconiosis. Dr. Joyce, the autopsy prosector, described his findings of black pigment and coal macules, which he designated as mild coal workers' pneumoconiosis. Dr. Naeye and Dr. Bush, who reviewed the tissue slides, agreed that they showed the presence of a small amount of black pigment, as well as pigment in two of the lymph nodes. But they also noted that there was no evidence of a reactive process, such as birefringent crystals, toxic silica, reticulin or fibrous reaction, or surrounding focal dust emphysema, that would be necessary to meet the minimum characteristics of coal workers' pneumoconiosis.

Dr. Naeye was a member of the committee that published its findings on coal workers' pneumoconiosis in 1979 in the *Archives of Pathology and Laboratory Medicine*. Acknowledging the very small amounts of pigment, he noted that there was no accompanying fibrosis, which is the result of tissue damage. The black pigment itself is carbon in an amorphous form, which is not toxic. He stated that the presence of the black pigment itself is insufficient to diagnose a coal mine induced disease, nor does it affect the functional capacity of the lung tissue. In other words, the mere presence of black pigment itself, whether on the surface of the lungs or in the tissues, is not sufficient for a diagnosis of coal workers' pneumoconiosis; nor is the presence of black pigment in the nodes.

According to Dr. Bush and Dr. Naeye, the findings of pigment in the two lymph nodes was of no diagnostic value for coal workers' pneumoconiosis, nor did it affect lung function.

Dr. Bush and Dr. Naeye are highly qualified pathologists; Dr. Naeye was on the committee that formulated and published the standards for the evaluation of coal workers' pneumoconiosis on autopsy. In contrast, Dr. Joyce's credentials are not in the record. Given their superior credentials, and their thorough discussion of their findings on the autopsy slides, I give most weight to the opinions of Dr. Bush and Dr. Naeye, and I find that the Claimant has not established the presence of pneumoconiosis by the autopsy evidence.

Medical Opinion Evidence

A claimant can also establish that the miner suffered from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis.

Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See, Hoffman v. B&G Construction Co.,* 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.,* 7 B.L.R. 1-295 (1984). A report which is better supported by the objective medical evidence of record may be accorded greater probative value. *Minnich v. Pagnotti Enterprises, Inc.,* 9 B.L.R. 1-89, 1-90 n.1 (1986); *Wetzel v. Director, OWCP,*8 B.L.R. 1-139 (1985).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra.* Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder of fact to decide. *Clark v. Karst-Robbins Coal Co.,* 12 B.L.R. 1-149 (1989)(en banc). Statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP,* 11 B.L.R. 1-135 (1988). An equivocal opinion, however, may be given little weight. *Justice v. Island Creek Coal Co.,* 11 B.L.R. 1-91 (1988); *Snorton v. Zeigler Coal Co.,* 9 B.L.R. 1-106 (1986).

a. *Dr. Mitchell*

Dr. Mitchell was also Mr. Whitt's treating physician, as reflected by his treatment notes, covering the period from November 1993 through June 2000 (DX 52). These notes reflect that Dr. Mitchell treated Mr. Whitt for hypertension, hypercholesterolemia, proteinuria, hyperglycemia, hyperlipidemia, diabetes mellitus, sinus bradycardia and possible coronary artery disease, and obesity. Evaluations showed ventricular tachycardia, which was corrected with ablation surgery in 1999.

Dr. Mitchell continued to treat Mr. Whitt after his diagnosis of lung cancer, and during his treatment. In his last treatment note of June 12, 2000, Dr. Mitchell noted that Mr. Whitt had moved to Princeton, where he was receiving treatment for his cancer from Dr. Gonzales-Chambers, and would be choosing a new family doctor as it was too far for him to drive to see Dr. Mitchell. He noted that Mr. Whitt had been hospitalized from May 11 to May 13, 2000 for a fever, and that his chest x-ray showed a right upper lobe infiltrate. He had been hospitalized about two weeks earlier for recurrence of pneumonia.

b. *Dr. German Iosif*

Dr. Mitchell referred Mr. Whitt to Dr. Iosif for a pulmonary evaluation (DX 50). Dr. Iosif saw Mr. Whitt on February 21, 2000, and reviewed his February 17, 2000 chest CT scan. He noted that spirometric testing showed a moderate obstructive ventilatory defect, with positive bronchodilator response. His impression was a right hilar mass in a middle aged individual with a prior history of cigarette smoking and moderate chronic obstructive pulmonary disease. He felt that the mass was a bronchogenic carcinoma of uncertain operability.

Dr. Iosif saw Mr. Whitt on June 7, 2000, where he noted a recent episode of fever and nonproductive cough, with radiologic features that favored radiation pneumonitis rather than an infectious pulmonary process.

c. *Dr. Rowena Gonzales-Chambers*

The record includes treatment notes from Dr. Rowena Gonzales-Chambers, in Princeton, West Virginia, from June 8, 2000 through February 2001 (DX 54). Her notes reflect that she was treating Mr. Whitt with chemotherapy in connection with his lung cancer diagnosis. Her examinations of the Claimant showed that his lungs were clear, with no wheezes or rales, up until September 6, 2000, when he had wheezing on the right upper lobe. Dr. Gonzales-Chambers' notes of that date reflect a partial collapse of the right upper and lower lobes, and atelectasis of the right middle lobe, which were probably post radiation changes, but she could not rule out right main stem bronchus obstruction or recurrent disease. Her notes also reflect that Mr. Whitt had suffered episodes of pneumonia after the start of chemotherapy treatment, and that he suffered from radiation pneumonitis.

By his October 2, 2000 visit, Mr. Whitt had developed extensive wheezing throughout his whole right lung field. Dr. Gonzales-Chambers felt that this was probably secondary to collapse of the right lung from fibrosis and radiation therapy, although she felt an endoscopic examination should be done to be sure it was not due to recurrent disease. Subsequently, a bronchoscopy showed no endobronchial lesion or evidence of disease recurrence.

Dr. Gonzales-Chambers' progress note from December 7, 2000, indicates that Mr. Whitt had recently been discharged for exacerbation of COPD, and that he was on steroids. By February 7, 2001, Mr. Whitt's metastatic cancer in his brain had progressed, and Dr. Gonzales-Chambers referred him to Dr. Prasad for consideration of gamma knife surgery.

d. *Dr. Vishnu Patel*

Dr. Patel treated Mr. Whitt on referral from Dr. Gonzales-Chambers. His treatment notes cover the period from October 11, 2000 to August 2001 (DX 54). Referring to Mr. Whitt's recent CT scan and x-ray, Dr. Patel noted that differential diagnoses could include post radiation fibrosis, recurrence of malignance, or an unusual infection. He did not feel that it was tuberculosis or bacterial pneumonia. In his Assessment, Dr. Patel included wheezing, most probably secondary to COPD, or possibly radiation.

On October 24, 2000, Dr. Patel noted right upper lobe atelectasis with a right perihilar shadow, most probably secondary to post radiation fibrosis. By August 21, 2001, Mr. Whitt was suffering from worsening dyspnea. Dr. Patel noted that the latest CT scan of August 7, 2001 showed chronic collapse of a portion of the right upper lung, and chronic right sided pleural effusion. He felt that Mr. Whitt's dyspnea was probably related to anxiety disorders.

e. *Dr. Norma Mullins*

Dr. Mullins examined Mr. Whitt at the Director's request on November 8, 2001 (DX 12). She reported his coal mine employment history, as well as his smoking history. On examination of the Claimant, she found his lungs to be clear to percussion, but with reduced breath sounds on auscultation, and wheezing with forced expiration. The chest x-ray showed pneumoconiosis 1/0,

s, s, a right hilar mass, and right upper lobe atelectasis. Dr. Mullins also performed pulmonary function and arterial blood gas studies.

Dr. Mullins' diagnosis was coal workers' pneumoconiosis by x-ray, due to coal dust exposure; cancer of the lung by chest x-ray and history, due to smoking and "unknown"; and COPD with a reversible component, due to coal workers' pneumoconiosis, smoking, and asthma. In her opinion, Mr. Whitt had a mild to moderate whole body impairment, which would have prevented the performance of his last job. She stated that this impairment was due 50% to coal workers' pneumoconiosis, and 50% to "other."

f. *Princeton Community Hospital*

Mr. Whitt was admitted to Princeton Community Hospital on several occasions, for treatment of infection and pneumonia, and headache, where he was treated by Dr. Gonzales-Chambers (DX 51). Dr. Gonzales-Chambers' reports do not include any past medical history of diagnosis of or treatment for pneumoconiosis, COPD, or any other pulmonary disorder.

Mr. Whitt was seen in the emergency room on November 18, 2000, for complaints of chest congestion. The chest x-rays showed a mass in the right hilum. Dr. Toler, who saw him in the emergency room, diagnosed Mr. Whitt with exacerbation of COPD and persistent wheezing, among other diagnoses. Dr. Gonzales-Chambers concurred, and admitted Mr. Whitt to the hospital for treatment. In her discharge summary, Dr. Gonzales-Chambers noted that Mr. Whitt's chest CT scan showed a mass in the left adrenal, very likely metastatic disease, and a mass like opacity in the right perihilar region which could be the combination of neoplasm, atelectasis, pneumonia, or organized effusion. Dr. V. Patel also evaluated Mr. Whitt, and concluded that he had acute exacerbation of COPD, with bronchospasm, most probably precipitated by an acute upper respiratory tract infection, most probably viral in nature. He did not see any evidence of pneumonitis versus CHF. He noted that the right perihilar mass on the chest x-ray was essentially changed, arguing against malignancy.

Mr. Whitt was admitted on June 2, 2001, for complaints of headache. Dr. Gonzales-Chambers noted that his chest CT scan showed a slight increase in the right side mass.

g. *Clinch Valley Medical Center*

The record includes reports from the Clinch Valley Medical Center, where Mr. Whitt was admitted on numerous occasions up to his death on February 6, 2002. The final discharge summary reflects that Mr. Whitt was taken to the emergency room on February 5, and died the following day (DX 54). Dr. Mitchell, who treated Mr. Whitt during his final admission, reported a final diagnosis of lung cancer with cerebral metastasis; type II diabetes mellitus; and hypertension. He indicated that an autopsy was performed for evaluation of black lung.

h. *CT Scans*

Mr. Whitt underwent a chest CT scan on February 17, 2000 (DX 52). Dr. Chubineh, the reviewing radiologist, found evidence of an ill defined right hilar mass, and a possible enlarged

retroaortic node. He suggested further evaluation by endoscopy and biopsy to rule out a malignant lesion.

Dr. Radoslav S. Nicholas reviewed Mr. Whitt's February 28, 2000 chest CT scan (DX 50). He noted a large right hilar mass and mediastinal lymphadenopathy, with some distal pneumonitis. The left adrenal mass was indicative of metastasis. Dr. Wheeler also reviewed Mr. Whitt's February 28, 2000 CT scan, finding no silicosis or coal workers' pneumoconiosis (DX 56). He noted a mass in the right hilum compatible with cancer or possible inflammatory disease, as well as a one cm. nodule in the lateral right mid lung compatible with inflammatory disease or tumor, with subtle interstitial infiltrate or fibrosis in the posterior superior segment of the right lower lung involving the pleura. He also found probable arteriosclerosis in the left coronary artery, but noted that the use of IV contrast made this uncertain.

Mr. Whitt underwent a CT scan of the thorax on July 6, 2000 (DX 54). Dr. Pathak, who reviewed the film, found extensive infiltrates in the right upper lobe, suggestive of a combination of pneumonia and post radiation fibrosis. He noted extensive associated pleural thickening, all new changes since the previous CT scan of February 28, 2000. He noted that the mass in the right hilum appeared to have shrunk, and that there was a 3.3 X e cm. mass in the left adrenal that could represent a metastatic deposit.

Dr. Ahmed reviewed a chest CT scan performed on August 25, 2000 (DX 51). He noted partial collapse of the right upper and lower lobe, and some atelectasis of the middle lose. He indicated that an opacity in the right perihilar region could be a combination of collapse, fibrosis/postradiation changes, and the neoplasm.

Dr. Wiot reviewed Mr. Whitt's CT scan of November 20, 2000, and found no evidence of coal workers' pneumoconiosis (DX 58). He did find significant volume loss in the right lung, with collapse of the right upper lobe, middle lobe, and superior segment of the right lower lobe. He noted mild thickening of the pericardium, and significant pleural disease on the right. He found minimal fibrotic change along the superior mediastinum on the left, not related to coal dust exposure. He indicated that the left lung field was otherwise unremarkable, except for mild emphysematous change.

Dr. Edward Aycoth reviewed Mr. Whitt's chest CT scan of March 7, 2001 (DX 51). He noted a slight decrease in infiltrative mass effect of the right perihilar region since the November 20, 2000 exam; there were no new nodules and the mass in the left adrenal gland was unchanged.

Dr. James E. Smitt III reviewed Mr. Whitt's August 7, 2001 chest CT scan, noting that it showed chronic collapse of a portion of the right lung, and chronic right pleural effusion (DX 51) Dr. Wiot also reviewed the August 7, 2001 CT scan, finding it similar to the CT scan of November 20, 2000. He found no evidence of coal workers' pneumoconiosis, but noted extensive changes on the right, with volume loss and pleural disease. He could not determine the etiology of the changes, but felt that the question of previous radiation treatment was important.

On October 16, 2001, Dr. David L. Groten reviewed the results of a chest CT scan. He noted a previously described area of atelectasis in the right perihilar region, with an associated small right pleural effusion.

i. *Death Certificate*

Dr. Mitchell completed Mr. Whitt's death certificate on February 6, 2002 (DX 44). He indicated that the immediate cause of Mr. Whitt's death was lung cancer with cerebral metastases. He did not list any other contributing causes.

j. *Dr. James R. Castle*

Dr. Castle reviewed medical records at the request of the Employer, and prepared a report dated March 1, 2004 (EX 6). Dr. Castle concluded that Mr. Whitt did not have coal workers' pneumoconiosis. He noted that Mr. Whitt worked in the coal mines for a sufficient period of time to have developed pneumoconiosis if he were a susceptible host. He also had a significant smoking history, another risk factor for the development of pulmonary symptoms, including chronic obstructive pulmonary disease, lung cancer, or atherosclerotic cardiovascular disease. In addition, Mr. Whitt had evidence of coronary artery disease by cardiac catheterization, and cardiac arrhythmias, another risk factor for the development of pulmonary symptoms.

Dr. Castle noted that with the exception of Dr. Patel's interpretation, none of the radiographic reports were indicative of coal workers' pneumoconiosis. The film that Dr. Patel reviewed was taken after Mr. Whitt completed radiation therapy. According to Dr. Castle, the s/s type opacities noted by Dr. Patel are not indicative of coal workers' pneumoconiosis, but are the type of change expected as a result of radiation therapy.

Dr. Castle stated that the studies done by Dr. Iosif at the time he diagnosed Mr. Whitt with lung cancer showed a mild degree of obstruction with a significant degree of reversibility, above the federal disability levels. After his therapy for lung cancer, Mr. Whitt showed a moderate degree of obstructive airways disease, with a significant degree of reversibility, most likely due to his therapy. In Dr. Castle's opinion, Mr. Whitt did not have a disabling degree of pulmonary function due to coal workers' pneumoconiosis, or any other coal mine dust induced lung disease.

Dr. Castle noted that Dr. Caffrey and Dr. Bush found the autopsy material to be negative for coal workers' pneumoconiosis, and that they described in detail why they did not find any such evidence, but only anthracotic pigmentation. In Dr. Castle's opinion, Mr. Whitt did not have clinical or pathological evidence of coal workers' pneumoconiosis.

Dr. Castle concluded that Mr. Whitt died as the result of extensive, widespread metastatic cancer of the lung, with significant brain metastasis. He felt that Mr. Whitt would have died as and when he did, regardless of his coal mining employment or coal dust exposure. His death was neither caused by, contributed to, nor hastened in any way by coal workers' pneumoconiosis. Nor was Mr. Whitt permanently and totally disabled by coal workers'

pneumoconiosis during his life. He was disabled as a whole man from his extensive cancer of the lung, due to his cigarette smoking.

According to Dr. Castle, even if he concluded that Mr. Whitt had radiographic or pathologic evidence of simple pneumoconiosis, it was too minimal to have caused him any respiratory "embarrassment" or to have participated in any in hastening his death.

Dr. Castle testified by deposition on March 22, 2004, after reviewing the additional material submitted by the Claimant (EX 7). None of this additional material caused Dr. Castle to change his opinions as set out in his medical report. Again, he noted that radiation therapy causes death of cells, resulting in the development of fibrosis or scar tissue, which can cause impairment in lung function. He stated that chemotherapy also results in the development of fibrosis and scar tissue, and further impairment in lung function. This would explain the results obtained in November 2001, and the development of some degree of restriction associated with the scar tissue due to radiation and chemotherapy.

Dr. Castle described the CT scan as a much more sensitive device than the x-ray, stating that if there were pneumoconiosis, a CT scan would pick it up before an x-ray. In Mr. Whitt's case, a number of CT scans were done in order to diagnose and evaluate his cancer. He pointed out that none of the physicians who reviewed these CT scans found coal workers' pneumoconiosis.

Dr. Castle discussed an article from the *Archives of Pathology and Laboratory Medicine* that determined the pathologic standards for the diagnosis of coal workers' pneumoconiosis. According to Dr. Castle, Mr. Whitt did not have the criteria listed in the article. But a pathologist unfamiliar with that article may find black pigment present, and conclude that it is coal workers' pneumoconiosis.

Other Evidence

At the hearing, the Claimant submitted a copy of her marriage certificate (CX A), which also appears at Director's Exhibit 43. The Claimant also submitted a copy of Mr. Whitt's Last Will and Testament (CX B); records from Princeton Community Hospital, which also appear in the Director's Exhibits (CX C); an article by the American Medical Association entitled "COPD: The Importance of Prevention," (CX D); a copy of Dr. Joyce's autopsy report, with handwritten notations on the numbering and listing of the cassettes and slides (CX E); and a copy of the Director's August 13, 2003 Proposed Decision and Order awarding benefits on Mr. Whitt's miner's claim (CX F).

Discussion

In this case, other than Dr. Joyce, whose opinion I have discussed above, the only physician to diagnose coal workers' pneumoconiosis was Dr. Mullins, who examined Mr. Whitt on November 18, 2001. However, the only basis for Dr. Mullins conclusion that Mr. Whitt had pneumoconiosis was the positive x-ray reading by Dr. Patel. I have found that the preponderance of the x-ray evidence does not establish pneumoconiosis. Thus, I find that Dr.

Joyce's opinion is not supported by the objective medical evidence, and I do not accord it any weight.

The record includes extensive treatment records from Mr. Whitt's treating physicians, Dr. Mitchell, Dr. Gonzales-Chambers, Dr. Iosif, and Dr. Patel, as well as from the Princeton Community Hospital and the Clinch Valley Medical Center. Despite the fact that most of these records reflect that Mr. Whitt was being treated for a pulmonary condition, i.e., lung cancer, and that he was evaluated extensively, including with x-rays, CT scans, and MRI's, there are no notations to even suggest any findings consistent with a diagnosis of coal workers' pneumoconiosis, or any coal dust induced pulmonary condition. Nor did the physicians who reviewed Mr. Whitt's medical records find any objective medical evidence to support a conclusion that he had coal workers' pneumoconiosis or a coal dust induced pulmonary condition.

Indeed, Dr. Mitchell's treatment notes, going back to 1993, do not reflect any diagnosis or treatment by Dr. Mitchell for any pulmonary disorder, up to the point of the discovery of Mr. Whitt's lung cancer. Dr. Mitchell's findings on physical examination consistently show that Mr. Whitt's lungs were clear, and Dr. Mitchell found no abnormalities on x-ray. Nor do any of Mr. Whitt's hospital reports reflect a previous diagnosis or history of coal workers' pneumoconiosis.

To be sure, the medical records indicate that toward the end of his life, Mr. Whitt developed COPD, as reflected in his pulmonary function studies. But none of his physicians suggested that Mr. Whitt's COPD was the result of his exposure to coal mine dust. Dr. Mullins indicated that Mr. Whitt had "COPD with reversible component" due to "CWP & smoking & asthma." I interpret this to mean that Mr. Whitt's "CWP," as well as his smoking and asthma, caused his COPD, but not to mean that Mr. Whitt had COPD as a result of his exposure to coal mine dust, which would be a finding of "legal" pneumoconiosis. But even if Dr. Mullins' report were so interpreted, I find that such a summary conclusion is not supported by any rationale or any objective medical evidence, nor is it consistent with the other medical evidence of record, including the numerous physicians who treated Mr. Whitt for his last two years.

In short, the record does not contain any reliable or persuasive medical opinions that Mr. Whitt suffered from coal workers' pneumoconiosis, or from any pulmonary condition as a result of his exposure to coal mine dust. Therefore, I find that the Claimant has not established that Mr. Whitt had pneumoconiosis by a preponderance of the medical opinion evidence.

Finally, I have weighed all of the evidence under § 718.202(a), including the x-ray evidence, and I find that the Claimant has not met her burden to establish that Mr. Whitt had pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000).

EstablishingDeath Due to Pneumoconiosis

Even if I were to find that Mr. Whitt had pneumoconiosis, the Claimant must also establish that he died due to pneumoconiosis in order to be entitled to benefits as a survivor under the Act. 20 C.F.R. § 718.205. The regulations require competent medical evidence which (1) establishes that the miner died due to pneumoconiosis; (2) that pneumoconiosis was a

substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or (3) that the presumption of § 718.304 is applicable.

Here, not one physician has even suggested that pneumoconiosis caused, hastened, or played any role whatsoever in Mr. Whitt's death. Dr. Joyce did not indicate in his autopsy report that his findings of pneumoconiosis had any part in Mr. Whitt's death. Dr. Mitchell, who treated Mr. Whitt for many years, and during his final confinement at the Princeton Community Hospital, and who requested the autopsy for the evaluation of black lung, indicated on Mr. Whitt's death certificate that he died from lung cancer with metastasis. He did not list pneumoconiosis as a contributing factor.

Indeed, Dr. Naeye, Dr. Bush, and Dr. Caffrey, who reviewed Mr. Whitt's medical records as well as his biopsy and autopsy slides, concluded that there was no evidence of pneumoconiosis, but that even if the black pigmentation found by Dr. Joyce were to be considered as pneumoconiosis, it was too mild to have played any part in Mr. Whitt's death. Dr. Castle came to the same conclusions after reviewing Mr. Whitt's medical records.

Based on the above I find that the Claimant has not established that Mr. Whitt's death was due to pneumoconiosis.

The Living Miner's Claim

Total Disability Due to Pneumoconiosis

Even if I were to find that the objective evidence of record established that Mr. Whitt had pneumoconiosis, I find that it does not establish that he had a total respiratory or pulmonary impairment due to pneumoconiosis.

The regulations as amended provide that a claimant can establish total disability by showing pneumoconiosis prevented the miner "[f]rom performing his or her usual coal mine work," and "[f]rom engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." 20 C.F.R. §718.204(b)(1). Where, as here, there is no evidence of complicated pneumoconiosis, total disability may be established by pulmonary function tests, arterial blood gas tests, evidence of cor pulmonale with right-sided congestive heart failure, or physicians' reasoned medical opinions, based on medically acceptable clinical and laboratory diagnostic techniques, to the effect that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in the miner's previous coal mine employment. 20 C.F.R. §718.204(b)(2). For a living miner's claim, total disability may not be established solely by the miner's testimony or statements. 20 C.F.R. §718.204(d)(5).

In this regard, Mr. Whitt underwent pulmonary function testing on February 21, 2000, and the results before the administration of bronchodilators showed an FEV1 of 2.10, and an FVC of 3.69; after administration of bronchodilators, the results were 2.39 on FEV1, and 3.99 on FVC (DX 50). Dr. Mullins administered pulmonary function testing on November 18, 2001.

Before the administration of bronchodilators, the FEV1 was 1.58; the FVC was 2.57, and the MVV was 57. After administration of bronchodilators, the FEV1 was 1.80, and the FVC was 2.92 (DX 12).

Dr. Mullins also administered arterial blood gas tests, obtaining pC02 values of 37.6 at rest and 35.7 after exercise, and p02 values of 72.1 at rest, and 82.5 after exercise (DX 12).

Here, there is no evidence of cor pulmonale, or right sided congestive heart failure; nor were the results of the arterial blood gas studies obtained by Dr. Mullins qualifying under the regulations. The results of the pulmonary function studies obtained by Dr. Mullins less than three months before Mr. Whitt's death, however, produced values that qualify under the regulations, at least before the administration of bronchodilators. Indeed, Mr. Whitt was treated at the hospital for exacerbation of COPD, and Dr. Patel's treatment notes include findings of COPD.

However, there is no objective reliable medical evidence to support a finding that Mr. Whitt's COPD was caused by coal workers' pneumoconiosis or by his exposure to coal mine dust. There is nothing to link the findings of black pigment, or coal macules, on autopsy, to Mr. Whitt's development of COPD. Dr. Bush attributed this obstructive impairment to centrilobular emphysema caused by Mr. Whitt's smoking history. He concluded that, even if the black pigment found on Mr. Whitt's lungs were considered to be coal workers' pneumoconiosis, the degree and extent was minimal, and did not contribute to any respiratory impairment or disability. Dr. Naeye felt that there was no evidence to support a conclusion that Mr. Whitt was disabled by bronchitis or emphysema, and that any impairment in lung function and resulting disability were not the consequence of coal workers' pneumoconiosis. Dr. Castle acknowledged that Mr. Whitt developed obstructive airways disease, but felt that it was most likely due to his therapy; even if he were to conclude that Mr. Whitt had simple pneumoconiosis, it was too minimal to have caused him respiratory impairment.

Dr. Joyce, who performed Mr. Whitt's autopsy, did not offer any opinion about the effect of the mild simple pneumoconiosis he found, or otherwise indicate that it caused any impairment in Mr. Whitt's respiratory function. Nor did any of the physicians who treated Mr. Whitt during his frequent hospitalizations during the last year of his life suggest that he had any pulmonary impairment, much less a disabling impairment, as a result of his exposure to coal mine dust.

In her report, Dr. Mullins indicated that Mr. Whitt had a mild to moderate "whole body" impairment which would have prevented him from performing his last job, due 50% to pneumoconiosis, and 50% to "other." The import of Dr. Mullins statements is not clear: while perhaps Dr. Mullins meant to say that half of Mr. Whitt's disabling "whole body" impairment was due to pneumoconiosis, it is not clear whether she meant that the impairment due to pneumoconiosis was, in itself, totally disabling. And although Dr. Mullins' report clearly indicates that she was aware of his cancer diagnosis and treatment, there is no discussion of the role that that disease and its treatment played in Mr. Whitt's pulmonary impairment, or any underlying rationale for her conclusions. I find that Dr. Mullins' report is poorly reasoned and not supported by the objective medical evidence, and I accord it little weight.

In contrast, Dr. Naeye, Dr. Bush, and Dr. Castle reviewed Mr. Whitt's medical record, including the autopsy findings; Dr. Naeye and Dr. Bush also examined the autopsy slides. I find that their opinions are comprehensive, well-reasoned, and supported by the objective medical evidence.

In short, there is no medical evidence to suggest that, up until he was diagnosed with and began treatment for lung cancer, Mr. Whitt had any pulmonary impairment of any degree or type. As his lung cancer progressed, along with his treatment, Mr. Whitt suffered the effects, including the partial collapse of his right lung, and the formation of fibrosis from the radiation and chemotherapy. Clearly, as he came closer to death, Mr. Whitt became totally disabled from a pulmonary standpoint. But there is simply no credible medical evidence to suggest that pneumoconiosis or exposure to coal mine dust played any role in that disability, as opposed to his lung cancer and its treatment.

Based on the above, I find that, even if I were to conclude that Mr. Whitt had pneumoconiosis, the Claimant has not established by a preponderance of the evidence that Mr. Whitt was totally disabled due to pneumoconiosis.

CONCLUSION

The Claimant has not established that the miner, William Whitt, suffered from pneumoconiosis that arose out of his coal mine employment. Nor has the Claimant established that during his lifetime, Mr. Whitt was totally disabled as a result of pneumoconiosis, or that his death was due to pneumoconiosis. Therefore, the Claimant is not entitled to benefits under the Act on either the living miner's or the survivor's claim.

ORDER

It is hereby ORDERED that the survivor's claim for benefits under the Act is hereby DENIED, and that the miner's claim for benefits under the Act is hereby DENIED.

A

LINDA S. CHAPMAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal to the Benefits Review Board within 30 days from the date of this Decision and Order, by filing a notice of appeal with the **Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.** A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room B2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.